AMENDED IN SENATE AUGUST 13, 2013

AMENDED IN ASSEMBLY APRIL 15, 2013

AMENDED IN ASSEMBLY MARCH 19, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 617

Introduced by Assembly Member Nazarian

February 20, 2013

An act ~~to amend Section 100501 of, and~~ to add Sections *100501.1*, 100506.1, 100506.2, 100506.3, 100506.4, and 100506.5 ~~to,~~ *to* the Government Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 617, as amended, Nazarian. California Health Benefit Exchange: appeals.

Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that take effect January 1, 2014. PPACA also requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers, as specified. Existing law establishes the California Health Benefit Exchange (Exchange) to implement the federal law. Existing law also requires the Exchange board to establish an appeals process for prospective and current enrollees of the Exchange that complies with all requirements of the federal act concerning the role of a state Exchange in facilitating federal appeals of Exchange-related determinations.

This bill would require the Exchange board to contract with the State Department of Social Services to serve as the Exchange appeals entity

designated to hear appeals of eligibility determination or redetermination for persons in the individual market. The bill would establish an appeals process for initial eligibility or enrollment determinations and ~~redetermination,~~ *redeterminations for insurance affordability programs, as defined*, including an informal resolution process, as specified, establishing procedures and timelines for hearings with the appeals entity, and notice provisions. The bill would also establish continuing eligibility for individuals during the appeals process.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

~~SECTION 1. Section 100501 of the Government Code is amended to read:~~

~~100501. For purposes of this title, the following definitions shall apply:~~

~~(a) "Board" means the board described in subdivision (a) of Section 100500.~~

~~(b) "Carrier" means either a private health insurer holding a valid outstanding certificate of authority from the Insurance Commissioner or a health care service plan, as defined under subdivision (f) of Section 1345 of the Health and Safety Code, licensed by the Department of Managed Health Care.~~

~~(c) "Exchange" means the California Health Benefit Exchange established by Section 100500.~~

~~(d) "Federal act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments to, or regulations or guidance issued under, those acts.~~

~~(e) "Fund" means the California Health Trust Fund established by Section 100520.~~

~~(f) "Health plan" and "qualified health plan" have the same meanings as those terms are defined in Section 1301 of the federal act.~~

~~(g) "MRMIB" means the Managed Risk Medical Insurance Board, established by Sections 12710 and 12710.1 of the Insurance Code.~~

~~(h) "SHOP Program" means the Small Business Health Options Program established by subdivision (m) of Section 100502.~~

~~(i) "State health subsidy program" means a program described in Section 1413(e) of the federal act.~~

~~(j) "Supplemental coverage" means coverage through a specialized health care service plan contract, as defined in subdivision (o) of Section 1345 of the Health and Safety Code, or a specialized health insurance policy, as defined in Section 106 of the Insurance Code.~~

SECTION 1. Section 100501.1 is added to the Government Code, to read:

100501.1. For purposes of this title, the following definitions shall apply:

(a) "Insurance affordability program" means a program that is one of the following:

(1) The state's Medi-Cal program under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(2) The state's children's health insurance program (CHIP) under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.).

(3) A program that makes available to qualified individuals coverage in a qualified health plan through the Exchange with advance payment of the premium tax credit established under Section 36B of the Internal Revenue Code.

(4) A program that makes available coverage in a qualified health plan through the Exchange with cost-sharing reductions established under Section 1402 of the federal act.

(b) "MRMIB" means the Managed Risk Medical Insurance Board, established by Sections 12710 and 12710.1 of the Insurance Code, or its successor.

SEC. 2. Section 100506.1 is added to the Government Code, to read:

100506.1. An applicant or enrollee has the right to appeal any of the following:

(a) Any action or inaction related to the individual's eligibility for or enrollment in ~~a state health subsidy~~ *an insurance affordability* program, or for advance payment of premium tax credits and cost-sharing reductions, or the amount of the advance payment of the premium tax credit and level of cost sharing, or eligibility for affordable plan options.

(b) An eligibility determination for an exemption from the individual responsibility penalty pursuant to Section 1311(d)(4)(H) of the federal act.

(c) A failure to provide timely notice of an eligibility determination or redetermination or an enrollment determination.

SEC. 3. Section 100506.2 is added to the Government Code, to read:

100506.2. (a) The entity making an eligibility or enrollment determination described in Section 100506.1 shall provide notice of the appeals process at the time of application and at the time of eligibility or enrollment determination *or redetermination*.

(b) The entity making an eligibility or enrollment determination described in Section 100506.1 shall also issue a combined eligibility notice, as defined by Section 435.4 of Title 42 of the Code of Federal Regulations. The combined eligibility notice shall contain all of the following:

(1) Information about each ~~state health subsidy~~ *insurance affordability* program for which an individual or multiple family members of a household have been determined to be eligible or ineligible and the effective date of eligibility and enrollment.

(2) Information regarding all of the bases of eligibility for non-Modified Adjusted Gross Income (MAGI) Medi-Cal and the benefits and services afforded to individuals eligible on those bases, sufficient to enable the individual to make an informed choice as to whether to appeal the eligibility determination or the date of enrollment.

(3) An explanation that the applicant or enrollee may appeal any action or inaction related to an individual's eligibility for or enrollment in ~~a state health subsidy~~ *an insurance affordability* program with which the applicant or enrollee is dissatisfied by requesting a state fair hearing consistent with Section 100506.4 and the provisions of Chapter 7 (commencing with Section 10950) of Part 2 of Division 9 of the Welfare and Institutions Code.

(4) Information on the applicant or enrollee's right to represent himself or herself or to be represented by legal counsel or an authorized representative as provided in subdivision (f) of Section 100506.4.

(5) An explanation of the circumstances under which the applicant's or enrollee's eligibility shall be maintained or reinstated pending an appeal decision, pursuant to Section 100506.5.

SEC. 4. Section 100506.3 is added to the Government Code, to read:

100506.3. The board shall enter into a contract with the State Department of Social Services to serve as the Exchange appeals entity designated to hear appeals of eligibility or enrollment determination or redetermination for persons in the individual market, pursuant to Section 100506 and Subpart F of Part 155 of Title 45 of the Code of Federal Regulations. Except as otherwise provided in this title, the hearing process shall be governed by the Medi-Cal hearing process established in Chapter 7 (commencing with Section 10950) of Part 2 of Division 9 of the Welfare and Institutions Code.

SEC. 5. Section 100506.4 is added to the Government Code, to read:

100506.4. (a) (1) Except as provided in paragraph (2), the State Department of Social Services, acting as the appeals entity, shall allow an applicant or enrollee to request an appeal within 90 days of the date of the notice of an eligibility or enrollment determination, unless there is good cause as provided in Section 10951 of the Welfare and Institutions Code.

(2) The appeals entity shall establish and maintain a process for an applicant or enrollee to request an expedited appeals process where there is immediate need for health services because a standard appeal could seriously jeopardize the appellant's life, health, or the ability to attain, maintain, or regain maximum function. If an expedited appeal is granted, the decision shall be issued within three working days or as soon as is required by the appellant's condition. If an expedited appeal is denied, the appeals entity shall notify the appellant within two days by telephone or commonly available electronic means, to be followed in writing, of the denial of an expedited appeal. If an expedited appeal is denied, the appeal shall be handled through the standard appeal process.

(b) Appeal requests may be submitted to the appeals entity by telephone, by mail, in person, through the Internet, through other commonly available electronic means, or by facsimile.

(c) The staff of the Exchange, the county, or MRMIB shall assist the applicant or enrollee in making the appeal request.

(d) (1) Upon receipt of an appeal, the appeals entity shall send timely acknowledgment to the appellant that the appeal has been

received. The acknowledgment shall include information relating to the appellant's eligibility for benefits while the appeal is pending, an explanation that advance payments of the premium tax credit while the appeal is pending are subject to reconciliation, an explanation that the appellant may participate in informal resolution pursuant to subdivision (g), and information regarding how to initiate informal resolution.

(2) Upon receipt of an appeal request, the appeals entity shall send, via secure electronic interface, timely notice of the appeal to the Exchange and the county and, if related to the Access for Infants and Mothers or the Healthy Families Program, MRMIB.

(3) Upon receipt of the notice of appeal from the appeals entity, the entity that made the determination of eligibility or enrollment being appealed shall transmit, either as a hardcopy or electronically, the appellant's eligibility and enrollment records for use in the adjudication of the appeal to the appeals entity.

(e) A member of the board, employee of the Exchange, a county, MRMIB, or the appeals entity shall not limit or interfere with an applicant or enrollee's right to make an appeal or attempt to direct the individual's decisions regarding the appeal.

(f) An applicant or enrollee may be represented by counsel or designate an authorized representative to act on his or her behalf, including, but not limited to, when making an appeal request and participating in the informal resolution process provided in subdivision (g).

(g) An applicant or enrollee who files an appeal shall have the opportunity for informal resolution, prior to a hearing, that conforms with all of the following:

(1) A representative of the Exchange, the county, or MRMIB shall contact the appellant and offer to discuss the determination with the appellant if he or she agrees.

(2) The appellant's right to a hearing shall be preserved if the appellant is dissatisfied with the outcome of the informal resolution process. The appellant or the authorized representative may withdraw the hearing request voluntarily or may agree to a conditional withdrawal that shall list the agreed-upon conditions that the appellant and the Exchange, county, or MRMIB shall meet.

(3) If the appeal advances to a hearing, the appellant shall not be required to provide duplicative information or documentation

that he or she previously provided during the application, redetermination, or informal resolution processes.

(4) The informal resolution process shall not delay the timeline for a provision of a hearing.

(5) The informal resolution process is voluntary and neither an appellant's participation nor nonparticipation in the informal resolution process shall affect the right to a hearing under this section.

(6) For eligibility or enrollment determinations for ~~state health subsidy~~ *insurance affordability* programs based on modified adjusted gross income (MAGI), the appellant may initiate the informal resolution process with the entity that made the determination, except that all of the following shall apply:

(A) The Exchange shall conduct informal resolution involving issues related only to the Exchange, including, but not limited to, exemption from the individual responsibility penalty pursuant to Section 1311(d)(4)(H) of the federal act, offers of affordable employer coverage, special enrollment periods, and eligibility for affordable plan options.

(B) Counties shall conduct informal resolution involving issues related to non-MAGI Medi-Cal.

(C) MRMIB shall conduct informal resolution involving issues related only to the Access for Infants and Mothers Program or the Healthy Families Program.

(7) The staff involved in the informal resolution process shall try to resolve the issue through a review of case documents, in person or through electronic means as desired by the appellant, and shall give the appellant the opportunity to review case documents, verify the accuracy of submitted documents, and submit updated information or provide further explanation of previously submitted documents.

(8) The informal resolution process set forth by the State Department of Social Services' Manual of Policies and Procedures Section 22-073 shall be used for the informal resolutions pursuant to this subdivision.

(h) (1) A position statement, as required by Section 10952.5 of the Welfare and Institutions Code, shall be electronically available at least two working days before the hearing on the appeal.

(2) The appeals entity shall send written notice, electronically or in hard copy, to the appellant of the date, time, and location of the hearing no later than 15 days prior to the date of the hearing. If the date, time, and location of the hearing are prohibitive of participation by the appellant, the appeals entity shall make reasonable efforts to set a reasonable, mutually convenient date, time, and location. The notice shall include the right of the appellant to request that the hearing be held via telephone or video conference and include instructions for submitting the request on the notice, by telephone or through other commonly available electronic means.

(3) The format of the hearing shall be in person, unless the appellant requests the hearing be held telephonically or via video conference pursuant to paragraph (2).

(4) The hearing shall be an evidentiary hearing where the appellant may present evidence, bring witnesses, establish all relevant facts and circumstances, and question or refute any testimony or evidence, including, but not limited to, the opportunity to confront and cross-examine adverse witnesses, if any.

(5) The hearing shall be conducted by one or more impartial officials who have not been directly involved in the eligibility or enrollment determination or any prior appeal decision in the same matter.

(6) The appellant shall have the opportunity to review his or her appeal record, case file, and all documents to be used by the appeals entity at the hearing, at a reasonable time before the date of the hearing as well as during the hearing.

(7) Cases and evidence shall be reviewed de novo by the appeals entity.

(i) Decisions shall be made within 90 days from the date the appeal is filed and shall be based exclusively on the application of the applicable laws and eligibility and enrollment rules to the information used to make the eligibility or enrollment decision, as well as any other information provided by the appellant during the course of the appeal. The content of the decision of appeal shall include a decision with a plain language description of the effect of the decision on the appellant's eligibility or enrollment, a summary of the facts relevant to the appeal, an identification of the legal basis for the decision, and the effective date of the decision, which may be retroactive.

(j) Upon adjudication of the appeal, the appeals entity shall transmit the decision of appeal to the entity that made the eligibility or enrollment determination via a secure electronic interface.

(k) If an appellant disagrees with the decision of the appeals entity, he or she may make an appeal request regarding issues relating to the Exchange to the federal Health and Human Services Agency within 30 days of the notice of decision through any of the methods in subdivision (b).

(*l*) An appellant may also seek judicial review to the extent provided by law. Appeal to the federal Department of Health and Human Services is not a prerequisite for seeking judicial review.

(m) Nothing in this section, or in Sections 100506.1 and 100506.2, shall limit or reduce an appellant's rights to notice, hearing, and appeal under Medi-Cal, county indigent programs, or any other public programs.

SEC. 6. Section 100506.5 is added to the Government Code, to read:

100506.5. For appeals of redetermination of Exchange advance premium tax credits or cost-sharing reductions, upon receipt of notice from the appeals entity that it has received an appeal, the entity that made the redetermination shall continue to consider the applicant or enrollee eligible for the same level of advance premium tax credits or costing-sharing reductions while the appeal is pending in accordance with the level of eligibility immediately before the redetermination being appealed.

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